Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 4, 2018	2017_484646_0016	026996-17	Resident Quality Inspection

Licensee/Titulaire de permis

COLLINGWOOD NURSING HOME LIMITED
250 CAMPBELL STREET COLLINGWOOD ON L9Y 4J9

Long-Term Care Home/Foyer de soins de longue durée

COLLINGWOOD NURSING HOME
250 CAMPBELL STREET COLLINGWOOD ON L9Y 4J9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

IVY LAM (646), GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 28, 29, 30; and December 1, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Services (DRS), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aides (HCA), Housekeeping Supervisor, Activity Director, Registered Dietitian (RD), Food Service Supervisor (FSS), Dietary Aides, Residents' Council President, Residents, Family Members, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspectors conducted a tour of the home, observed resident home areas, observation of care delivery processes including medication passes and meal delivery services, infection prevention and control, accommodation -- housekeeping, and review of the home's policies and procedures related to Skin and Wound Care, Minimizing of Restraining, and Nutrition and Hydration; and review of resident health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #001 was triggered by the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) census record on an identified date for an identified alteration to skin integrity from the Resident Quality Inspection (RQI).

Review of resident #001's assessment record on an identified date revealed that the resident developed an alteration of skin integrity on an identified date to an identified part of his/her body, and that at the time of assessment, the alteration of skin integrity had further worsened. The resident was treated and referred to the wound care coordinator (WCC). The assessment by the WCC on an identified date, revealed that resident #001 had the worsened alteration of skin integrity on his/her identified part the body of an identified size. The assessment record for treating the alteration of skin integrity revealed an identified number of interventions, including identified equipment to be provided, and identified care to be provided.

Review of the resident #001's written plan of care failed to reveal that resident had the identified alteration of skin integrity on the identified part of his/her body. The written plan of care addressed Skin Care Program Prevention Measures due to a number of identified factors, with a goal to maintain skin integrity and had guide the staff to assess the skin areas AM and HS, document results and notify nurse of any identified types of alterations of skin integrity.

Interview with PSW #116 revealed that he/she was not aware that resident #001 had a worsened alteration of skin integrity on the identified part of his/her body, and he/she was not aware of what interventions should be implemented to the resident.

The PSW confirmed he/she attended morning reports but did not understand clearly that resident #001 had the alteration of skin integrity and had to be provided an identified care at identified time intervals.

Interview with WCC confirmed that resident #001's worsened alteration of skin integrity to the identified part of his/her body had not been documented in the written plan of care so no clear direction had been given to the PSW as provide the identified care. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #001 was triggered by the MDS census record and staff interview for an identified alteration in skin integrity from the RQI.

Review of resident #001’s assessment record dated on an identified date to an identified part of his/her body, and that at the time of assessment, the alteration of skin integrity had further worsened. The resident was treated and referred to WCC. The assessment by the WCC on an identified date revealed that resident #001 had the worsened alteration of skin integrity. The care, treatment and equipment used for treating the alteration of skin integrity were identified, as well as to assess the alteration to skin integrity weekly.

Review of resident #001's weekly skin assessment record revealed that resident #001's was assessed on three identified dates between a four-month period. The weekly skin assessment record failed to reveal that the resident’s alteration of skin integrity was assessed weekly by a member of the registered nursing staff.

Interview with the WCC confirmed that he/she had been doing skin assessment rounds to resident #001 but because resident #001’s alteration of skin integrity had been healing at that time the WCC did not reassess the alteration of skin integrity every week as clinically was indicated by registered staff.

Interview with Director of Resident Services (DRS) confirmed that the registered staff was expected to reassess the residents' alterations of skin integrity weekly on his/her rounds. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

This Nutrition and Hydration inspection was initiated for resident #001, related to

significant weight change from the most recent MDS. Review of resident's MDS and weight history on an identified date revealed that the resident had experienced a significant weight change in one month.

Review of the dietitian's assessment and recommendations, and the resident's nutrition care plan revealed that the resident was to be provided an identified oral nutritional supplement (ONS) at two identified times per day, and another type of ONS at three identified times in the day.

Review of resident's electronic medical administration records (eMAR) in August, and his/her current eMAR revealed that the resident's second type of ONS was given and documented. However, there was no documentation to monitor if resident #001's first type of ONS was provided and consumed.

Interviews with PSW #111, RPN #109 and RN #110 revealed that second type of ONS is tracked by the nurses, but other ONS are given on the snack cart by the PSWs. The PSWs will record how much is taken by the resident on Point of Care (POC), but this is counted as part of the total fluids the resident receives at meals or snacks, and there is no specific monitoring or tracking for ONS other than the second identified ONS.

PSW #111 further revealed that he/she was not aware of any other methods that the home was using to track resident's snack and supplement intake.

Interview with the Food Service Supervisor (FSS) and the Registered Dietitian (RD) revealed that, with the exception of Resource, there is currently no tracking on POC or pointclickcare (PCC) to determine residents' acceptance of nutrition interventions.

The FSS and RD further revealed that a paper-tracking form was trialled to document residents' acceptance of nutrition interventions, but that staff did not properly fill out the tracking forms, and the dietary department will re-evaluate this process. The FSS and RD confirmed that there is currently no system in place to monitor and evaluate the specialized snack intake, including nutrition supplements other than the second identified type of ONS, for residents with identified risks related to nutrition and hydration. [s. 68. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

This Nutrition and Hydration inspection was initiated for resident #001, related to significant weight change from the most recent MDS. Review of resident's MDS and weight history on an identified date revealed that the resident had experienced a significant weight change in one month.

Review of the dietitian's assessment and recommendations, and the resident's nutrition care plan revealed that the resident was to be provided an identified oral nutritional supplement (ONS) at two identified times per day, and another type of ONS at three identified times in the day.

Review of resident's electronic medical administration records (eMAR) in August, and

his/her current eMAR revealed that the resident's second type of ONS was given and documented. However, there was no documentation to monitor if resident #001's first type of ONS was provided and consumed.

Interviews with PSW #111, RPN #109 and RN #110 revealed that second type of ONS is tracked by the nurses, but other ONS are given on the snack cart by the PSWs. The PSWs will record how much is taken by the resident on Point of Care (POC), but this is counted as part of the total fluids the resident receives at meals or snacks, and there is no specific monitoring or tracking for ONS other than the second identified ONS.

PSW #111 further revealed that he/she was not aware of any other methods that the home was using to track resident's snack and supplement intake.

Interview with the Food Service Supervisor (FSS) and the Registered Dietitian (RD) revealed that, with the exception of Resource, there is currently no tracking on POC or pointclickcare (PCC) to determine residents' acceptance of nutrition interventions, including Boost.

The FSS and RD further revealed that a paper-tracking form was trialled to document residents' acceptance of nutrition interventions, but that staff did not properly fill out the tracking forms, and the dietary department will re-evaluate this process. The FSS and RD confirmed that there is currently no system to in place to monitor and evaluate the specialized snack intake, including nutrition supplements other than the second identified type of ONS, for residents with identified risks related to nutrition and hydration. [s. 68. (2) (d)]

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is (b) complied with.

This Nutrition and Hydration inspection was initiated for resident #003, related to significant weight change from the census review and the resident's weight history over one month.

Review of the home's policy titled 'Weight Assessment' (Policy #D004, date revised 1/14, date reviewed 8/15) revealed that the nursing staff were to follow the nursing weight policy for taking and recording weights. The policy further revealed that the Dietitian/Designee was responsible for reviewing all the weights on a monthly basis. And

by the agreed date each month, nursing will have identified anyone with a weight change of greater than or equal to 5% in one month, 7.5% in three months, and 10% in six months.

The policy further revealed that the nursing staff were to reweigh residents whose weights are questionable (2% weight change), and the registered staff were to refer to the RD if weight is unchanged. The policy further details that if a discrepancy still exists and the change is unplanned or undesirable, the RD was to request for the resident be placed on weekly weight schedule, or more often as ordered by physician

Review of the resident's progress notes did not reveal any referrals for significant weight change during this time period.

Interview with RPN #109 and the RD revealed that there was no RD referral for resident #003's significant weight change for the identified significant weight change.

Interview with the RD further revealed that he/she had not received a weight referral from the registered staff for resident #003's significant weight, and he/she had not communicated with the registered staff regarding resident #003's identified weight change.

Interview with the DRS revealed that the staff should follow the procedures for weight assessment as per the home's Weight Assessment policy, and that this was not followed for resident #003's significant weight change. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status

This Nutrition and Hydration inspection was initiated for resident #002, related to his/her significant weight change from the census review and the resident's weight history. Review of resident #002's progress notes did not reveal any referral to the dietitian was made for this significant weight change.

Interview with RPN #109 revealed that the PSWs took resident weights, and the registered staff entered the information on PCC, and it was the home's process to refer to the RD if there were significant weight change. Interview with RN #110 revealed that the recorded weight on the identified month for resident #002 is likely incorrect, as the resident's weight has usually been stable. RN #110 further revealed that corrections to residents' weight records was done by the ADOC.

Interview with the RD revealed that resident #002's at the identified month was likely incorrect, and he/she was aware of this significant weight change recorded, but was waiting for a new weight in the next month and had neither discussed with registered staff for the accuracy of the resident's weight on the identified month, nor requested for a repeated weight for the identified month.

Interview with the ADOC revealed that it is the home's expectation to use an interdisciplinary approach of assessment when residents experience significant weight change, where the registered staff would refer to the RD if there is a significant weight change for a resident, to provide input for the RD to assess. The ADOC further revealed that resident #002's weight on the identified month was a mistake, and should have been corrected by the ADOC or the RD, to strike out the weight and request for a reweight, but that process was missed at the time for resident #002. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. This Nutrition and Hydration inspection was initiated for resident #003, related to significant weight change in one month from the census review and the resident's weight history.

Review of the resident's progress notes did not reveal any referrals for significant weight change during this time period.

Interview with PSW #104 revealed that PSWs are given a blank weight sheet at the beginning of the month, and residents are weighed on bath days. PSW #104 further revealed that the ADOC will let staff know if they need to reweigh the resident in the following week.

Interview with RPN #109 revealed that it is the home's process for the PSWs take residents' weights, and for registered staff enter the information on PCC, and it was the home's process to refer to the RD if there were significant weight change. Interview with the ADOC revealed that it was the home's process to weigh residents on shower days at the beginning of the month, and within one week, the resident would be reweighed if a discrepancy was found.

Interview with RPN #109 and the RD revealed that there was no RD referral for resident #003's significant weight change for the identified significant weight change.

Interview with the RD further revealed that he/she was not sure if the weight loss on the identified month was accurate, but had not received a weight loss referral from the registered staff for resident #003's significant weight, and he/she had not communicated with the registered staff regarding resident #003's weight change during the identified period.

Interview with the ADOC revealed that it is the home's expectation to use an interdisciplinary approach of assessment when residents experience significant weight change. The ADOC further revealed that there was no interdisciplinary assessment for resident #003's significant weight change during the identified months. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 8th day of January, 2018

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.